Medical Records

Civil Action Number: 2:17-01146
Claimant: Trish Ann Fontana
Account Number: 197-56-3849

Exhibits

Exhibit No.	Description	Page No.	No. of Pages
12F	Outpatient Hospital Records, dated 04/22/2014 to 10/15/2014, from UPMC Mercy	361-400	40

DATE: April 18, 2018

The documents and exhibits contained in this administrative record are the best copies obtainable.

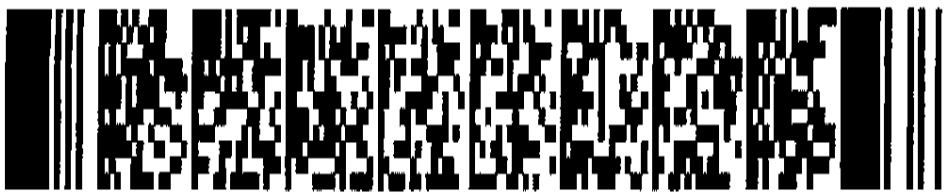
EXHIBIT NO. 12F
PAGE: 1 OF 40

INSERT THIS END FIRST

Please include this barcode cover sheet as the first page of each set of documents returned.

Fax the evidence to this fax number:

(877)548-8812



RQID:00000000000000000128124490 SITE:Y12 DR:S
SSN:197563849 DOCTYPE:5032 RF:D CS:afa5

Claimant: Trish Ann Fontana
SSN: 197-56-3849

EXHIBIT NO. 12F
PAGE: 2 OF 40

SOCIAL SECURITY ADMINISTRATION

Refer To:
197-56-3849
Trish Ann Fontana

Office of Disability Adjudication and Review
Suite 2308
1000 Liberty Avenue
Pittsburgh, PA 15222-4023
Tel: (866)331-2291 / Fax: (412)644-4200

September 30, 2014

Trish Ann Fontana
3130 Glendale Ave
Pittsburgh, PA 15227

NOTICE OF HEARING

Please bring this notice of hearing with you to the hearing.

I have scheduled your hearing for:

Day: Wednesday **Date:** December 3, 2014 **Time:** 10:30 AM Eastern (ET)

Room: 1 **Address:** William S Moorehead Federal Building
Suite 2308
1000 Liberty Avenue
Pittsburgh, PA 15222

It Is Important That You Attend Your Hearing

I have set aside this time for you to tell me about your case. If you do not attend the hearing and I do not find that you have a good reason, I may **dismiss** your request for hearing. I may do so without giving you further notice.

You may ask us if you want to appear by telephone. I will grant your request if I find that extraordinary circumstances prevent you from appearing in person or by video teleconferencing.

You **must** bring valid picture identification (ID) to your hearing. Examples of acceptable picture ID include a:

- **Current and valid U.S. State driver's license;**
- **U.S. State-issued identity card;**

Suspect Social Security Fraud?
Please visit http://oig.ssa.gov/r or call the Inspector General's Fraud Hotline at 1-800-269-0271 (TTY 1-866-501-2101).

See Next Page

If you want to see your file before the date of your hearing, please call this office and make arrangements. If your file is electronic, you may ask for a copy on a compact disc. You may also review your file on the day of your hearing if you come in at least 30 minutes before the time set for your hearing. Please call us in advance if you will need more than 30 minutes to review your file.

Issues I Will Consider

The hearing concerns your application of March 20, 2013, for a Period of Disability and Disability Insurance Benefits under sections 216(i) and 223(a) of the Social Security Act (the Act). I will consider whether you are disabled under sections 216(i) and 223(d) of the Act.

Under the Act, I will find you disabled if you have a physical or mental condition(s) that:

- Keeps you from doing any substantial gainful work; **and**
- Has lasted 12 straight months, can be expected to last for 12 straight months, or can be expected to result in death.

I will follow a step-by-step process to decide whether you are disabled. I will stop the process at the first step I can make a decision. The steps in this process look at:

- Any work you have done after your condition(s) began;
- The severity of your condition(s);
- Whether you can do the kind of work you did in the past; and
- Whether you can do any other kind of work considering your age, education, and work experience.

I will also consider whether you have enough earnings under Social Security to be insured for a Period of Disability and Disability Insurance Benefits. If you do, I must decide whether you became disabled while you were insured.

Our regulations explain the rules for deciding whether you are disabled and, if so, when you became disabled. These rules are in the Code of Federal Regulations, Title 20, Chapter III, Part 404, Subpart B and Subpart P.

More About the Issues

If I find that you have been disabled, I will also consider whether your disability continues through the date of the decision or whether your condition(s) has improved.

- I will ask you and any other witnesses questions that will help me make a decision in your case.
- We will make an audio recording of the hearing.

Travel Costs

We can pay certain travel costs when you, your representative, or needed witnesses must travel more than 75 miles to the hearing. A sheet is enclosed to tell you about our rules for paying travel costs. Please call this office if you want more information.

The Decision

After the hearing, I will issue a written decision and mail it to you. The decision will explain my findings of fact and conclusions of law. I will base my decision given all the evidence of record, including the testimony at your hearing.

If You Have Any Questions

If you have any questions, please call, **(866)331-2291**, or write this office. For your convenience, our address is on the first page of this notice.

Sincerely,

John J. Porter
Administrative Law Judge

Enclosures:
Form HA-504 (09-2003) ef (09-2014)
Form HA-L84 (Vocational Expert Letter)

cc: Lawrence Bolind
238 Main Street
Imperial, PA 15126

Trish Ann Fontana 197-56-3849

Exhibits

1 2014.04.22 UPMC Mercy Hospital - Rosenthal, MD - After Hospital Care Plan

2 2014.08.05 Rothfus, MD - Office Visit Report

3 2014.10.15 Richman, MD - Office Visit Report

4 2014.11.06 UPMC Mercy Hospital - Frank, MD - After Hospital Care Plan

5 2014.11.19 Orthopedics Mercy Office - Physical Therapy Report

6 Fee Waiver

7 Claimant's Forms

Trish Ann Fontana 197-56-3849

Exhibits

No. 1

EXHIBIT NO. 12F
PAGE: 7 OF 40

UPMC Mercy

1400 Locust St.
Pittsburgh, PA 15219

Bring This After Hospital Care Plan To ALL Appointments

After Hospital Care Plan For: FONTANA, TRISH A
Admission Date: 4/22/2014 10:07 AM

Questions about this packet?
412-232-7231

Discharging Provider/Nurse

Attending Physician: Bruce Rosenthal NPI Number: 1669461976
Nurse: Nicole

New prescriptions provided at the time of service

New Prescriptions:

MEDROL DOSEPAK 4 MG ORAL TABLET 1 PACKET(S) BY MOUTH ONCE; AS DIRECTED ON PACKAGE LABELING; START THIS MEDICATION ON: TUE, APR 22 AT 1:52 PM; Dispense: 21 TAB(S); Prescription Printed

OXYCODONE 5 MG ORAL TABLET 1 TAB BY MOUTH EVERY 6 HOURS; AS NEEDED FOR FOR PAIN FOR 5 DAYS; Dispense: 20 TAB(S); Refills: 0; Prescription Printed

Medications Given in the ED:

4/22 11:18 am ibuprofen 600 mg By Mouth
4/22 11:18 am acetaminophen 1 gm By Mouth

Medication Information Comment:

What is my main medical problem?
Lumbar radiculopathy

Appointment Details

Provider	Address	When	Comment
JORY RICHMAN	(412) 232-5800 1350 LOCUST ST #220 MERCY PROFESSIONAL BLD, PITTSBURGH, PA, 15219 (412) 664-3030 MCKEESPORT HOSPITAL SHAW BUILDING, 3RD FLOOR 1500 FIFTH AVENUE, MCKEESPORT, PA, 15132	AS SOON AS POSSIBLE	

When scheduling your appointments, please confirm the address and telephone number listed is current. If you would like assistance in finding a doctor or making your appointments, please call (800) 533-UPMC (8762). It is *important* to keep all of your appointments.

Procedures/Tests Performed:

4/22 12:52 pm Lumbar Spine 2 or 3 Views Xray

Summary of Relevant Procedures/Tests Performed:

The discharging provider did not include a summary of these tests. Please review these test results with your next care provider or primary care physician.

Labs Collected in the ED:

No lab data resulted.

What are my medication allergies?

Allergies:

Mold; Mites; Pollen; Grass; penicillins [hives]; Pentothal [hives]; morphine [nausea/vomiting]

Visit Information Comment:

The care you received in the Emergency Department is only part of your ongoing health care. It is important that you make arrangements for follow-up with your primary physician or other appropriate physician or clinic. We recommend that you be seen for re-evaluation and further care as indicated in these Discharge Instructions.

Based on the information provided to us, we have reviewed your medications. Unless you were told otherwise, you should continue your medications as prescribed.

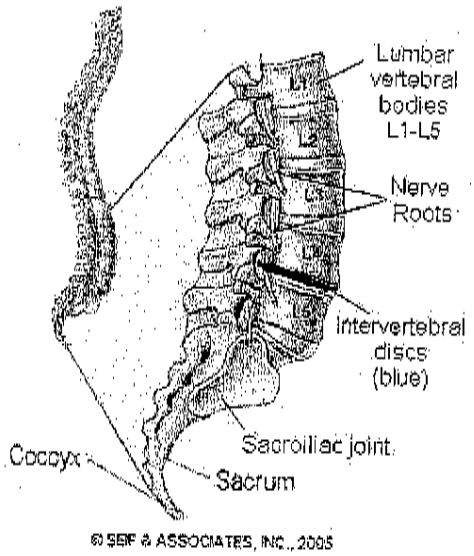
As part of UPMC's care and commitment, an electronic copy of your UPMC discharge instructions can be obtained via email. Please email your full name, date of discharge, date of birth and the hospital from which you were discharged to the email account Patient_instructions@upmc.edu to obtain an electronic copy.

UPMC Mercy would like to thank you for allowing us to assist you with your healthcare needs.

Emergency Medicine

Lumbosacral Radiculopathy

Lumbosacral radiculopathy is a pinched nerve or nerves in the low back (*lumbosacral* area). When this happens you may have weakness in your legs and may not be able to stand on your toes. You may have pain going down into your legs. There may be difficulties with walking normally. There are many causes of this problem. Sometimes this may happen from an injury, or simply from arthritis or boney problems. It may also be caused by other illnesses such as diabetes. If there is no improvement after treatment, further studies may be done to find the exact cause.



DIAGNOSIS

X-rays may be needed if the problems become long standing. Electromyograms may be done. This study is one in which the working of nerves and muscles is studied.

HOME CARE INSTRUCTIONS

- Applications of ice packs may be helpful. Ice can be used in a plastic bag with a towel around it to prevent frostbite to skin. This may be used every 2 hours for 20 to 30 minutes, or as needed, while awake, or as directed by your caregiver.
- Only take over-the-counter or prescription medicines for pain, discomfort, or fever as directed by your caregiver.
- If physical therapy was prescribed, follow your caregiver's directions.

SEEK IMMEDIATE MEDICAL CARE IF:

- You have pain not controlled with medications.
- You seem to be getting worse rather than better.
- You develop increasing weakness in your legs.
- You develop loss of bowel or bladder control.
- You have difficulty with walking or balance, or develop clumsiness in the use of your legs.
- You have a fever.

MAKE SURE YOU:

- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

Document Released: 12/18/2006 Document Revised: 03/11/2013 Document Reviewed: 08/07/2009

Trish Ann Fontana 197-56-3849

Exhibits

No. 2

EXHIBIT NO. 12F
PAGE: 13 OF 40

Office Visit

Fontana, Trish A (6/2/1967)

Intrepretation Author
ROTHFUS,WILLIAM E

Study Result

CLINICAL HISTORY:
MR2 G103/DX:SPONDYLOLISTHESIS CONGENITAL.

COMPARISON:
Plain film x-rays of 04/22/2014.

TECHNIQUE:
Sagittal and axial T1 and T2-weighted sequences.

FINDINGS:
Bone marrow intensity is normal. The conus medullaris is normal. There is grade 1 anterolisthesis of L4 on 5. Bone marrow intensity is normal.

T11-T12 disc space is narrowed and there is posterior bulging with mild impression on the ventral thecal sac.

T12-L1 disc is normal.

L1-L2 disc shows diffuse bulging. There is a posterior annular fissure and a small protrusion paracentrally on the left side mildly impressing the ventral thecal sac.

At L2-L3 there is mild diffuse bulging. This is more prominent to the left.

L3-L4 shows a normal disc appearance. There is mild ligamentum flavum hypertrophy.

At L4-L5 there is degenerative facet disease bilaterally. Ligamentum flavum hypertrophy is present. There is diffuse disc bulging and anterolisthesis. Left greater than right S stenosis is present due to asymmetric facet capsule-ligamentum flavum hypertrophy. There is mild foraminal encroachment bilaterally.

At L5-S1 the disc space is markedly narrowed. There is left lateral marginal osteophytes on the left side encroaching on the left L5 nerve root, this is associated with moderate foraminal stenosis.

IMPRESSION
IMPRESSION:
3 to 4 mm anterolisthesis of L4 on L5 with associated diffuse disc bulging, facet degenerative changes and moderate to severe lateral recess and foraminal stenosis, left greater than right. There is moderate to severe central stenosis as well. Of note, this is of degenerative listhesis; there is no evidence of pars defect.

Degenerative L5-S1 disc disease with marginal osteophyte and moderate

left foraminal stenosis encroaching on the left L5 nerve root.

Imaging

MR LUMBAR SPINE WITHOUT CONTRAST (Order #154817181) on 7/31/2014 - Imaging Information

Result History

MR LUMBAR SPINE WITHOUT CONTRAST (Order #154817181) on 8/5/14 - Order Result History Report.

Result Entered By

Name	Date
RAD, RESULTS	8/5/2014

Trish Ann Fontana 197-56-3849

Exhibits

No. 3

EXHIBIT NO. 12F
PAGE: 16 OF 40

Office Visit

Fontana, Trish A (6/2/1967)

Progress Notes Info

Author	Note Status	Last Update User	Last Update Date/Time
Richman, Jory D, MD	Signed	Richman, Jory D, MD	10/15/2014 4:45 PM

Progress Notes

Trish A Fontana comes in today complaining of persistent lower back pain that radiates into both lower extremities although not purely in a dermatomal pattern. She has a grade 1 degenerative spondylolisthesis at L4-5 was rather marked spinal stenosis at that level. She has no sciatic tension signs and no motor deficits in her lower extremities.

I had a lengthy discussion with Trish and her husband regarding treatment options. She is anxious to avoid surgical intervention at this point and she does get reasonably good relief using Neurontin and Ultram which were refilled today we discussed the option of yoga. If there is no improvement we also discussed the option of a posterior lumbar decompression and fusion at L4-5. I will see her back as needed

MyUPMC Unreleased Notes

No notes found.

Visit Information

	Provider	Department	Encounter #
10/15/2014 11:50 AM	Jory D Richman, MD	Ortho Mercy Ofc	188048356

Trish Ann Fontana 197-56-3849

Exhibits

No. 4

UPMC Mercy

1400 Locust St.
Pittsburgh, PA 15219

Bring This After Hospital Care Plan To ALL Appointments

After Hospital Care Plan For: FONTANA, TRISH A
Admission Date: 11/06/2014 9:23 AM

Questions about this packet?
412-232-7231

Discharging Provider/Nurse

Attending Physician: Robert Frank NPI Number: 1417944059
Nurse: Adam

EXHIBIT NO. 12F
PAGE: 19 OF 40

New prescriptions provided at the time of service

New Prescriptions:

MEDROL DOSEPAK 4 MG ORAL TABLET 1 PACKET(S) BY MOUTH ONCE; AS DIRECTED ON PACKAGE LABELING; Dispense: 21 TAB(S); Refills: 0; Prescription Printed

AMBIEN 10 MG ORAL TABLET 1 TAB BY MOUTH AT BEDTIME; AS NEEDED FOR FOR SLEEP FOR 10 DAYS; Dispense: 10 TAB(S); Refills: 0; Prescription Printed

Medications Given in the ED:

None as per nursing (eMAR)

Medication Information Comment:

What is my main medical problem?
Cervical strain; Chronic pain; Lumbar spine strain; Thoracic sprain

Appointment Details			
Provider	**Address**	**When**	**Comment**
DOCTOR UNKNOWN		WITHIN 3 TO 5 DAYS	
JORY RICHMAN	MERCY PROFESSIONAL BUILDING 1350 LOCUST STREET, SUITE 220 412-232-5800, PITTSBURGH, PA, 15219 (412) 232-5800 1350 LOCUST ST #220 MERCY PROFESSIONAL BLD, PITTSBURGH, PA, 15219 (412) 664-3030 DEPARTMENT OF ORTHOPAEDICS UPMC MCKEESPORT HOSPITAL MANSFIELD BUILDING, LEVEL A , 1500 FIFTH AVENUE, MCKEESPORT, PA, 15132	AS SOON AS POSSIBLE	

When scheduling your appointments, please confirm the address and telephone number listed is current. If you would like assistance in finding a doctor or making your appointments, please call (800) 533-UPMC (8762). It is *important* to keep all of your appointments.

Procedures/Tests Performed:

11/06 11:23 am Cervical Spine 3 Views or Less
11/06 11:23 am Lumbar Spine 2 or 3 Views Xray

EXHIBIT NO. 12F
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11/06 11:32 am None
11/06 11:32 am Thoracic Spine w/ Swimmers Views Xray

Summary of Relevant Procedures/Tests Performed:

The discharging provider did not include a summary of these tests. Please review these test results with your next care provider or primary care physician.

Labs Collected in the ED:

No lab data resulted.

What are my medication allergies?

Allergies:

Mold; Mites; Pollen; Grass; penicillins [hives]; Pentothal [hives]; morphine [nausea/vomiting]

Visit Information Comment:

The care you received in the Emergency Department is only part of your ongoing health care. It is important that you make arrangements for follow-up with your primary physician or other appropriate physician or clinic. We recommend that you be seen for re-evaluation and further care as indicated in these Discharge Instructions.

Based on the information provided to us, we have reviewed your medications. Unless you were told otherwise, you should continue your medications as prescribed.

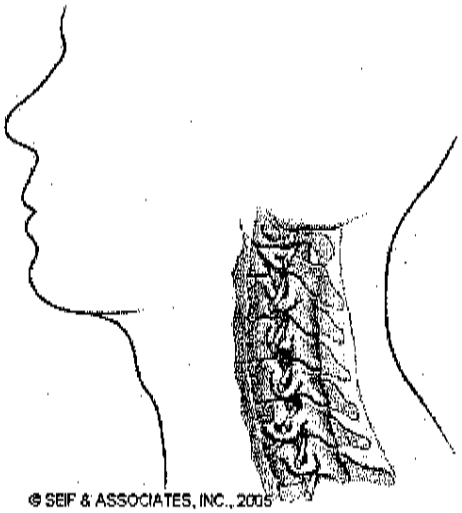
As part of UPMC's care and commitment, an electronic copy of your UPMC discharge instructions can be obtained via email. Please email your full name, date of discharge, date of birth and the hospital from which you were discharged to the email account Patient_instructions@upmc.edu to obtain an electronic copy.

UPMC Mercy would like to thank you for allowing us to assist you with your healthcare needs.

Emergency Medicine

Cervical Sprain

A cervical sprain is when the ligaments in the neck stretch or tear. The ligaments are the tissues that hold the neck bones in place.



HOME CARE

- Put ice on the injured area.
  - Put ice in a plastic bag.
  - Place a towel between your skin and the bag.
  - Leave the ice on for 15 to 20 minutes, 3 to 4 times a day.
- Only take medicine as told by your doctor.
- Keep all doctor visits as told.
- Keep all physical therapy visits as told.
- If your doctor gives you a neck collar, wear it as told.
- **Do not** drive while wearing a neck collar.
- Adjust your work station so that you have good posture while you work.
- Avoid positions and activities that make your problems worse.
- Warm up and stretch before being active.

GET HELP RIGHT AWAY IF:

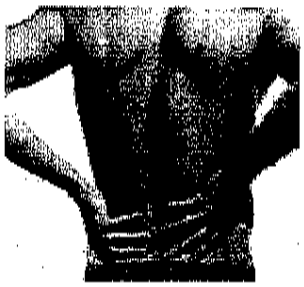
- You are bleeding or your stomach is upset.
- You have an allergic reaction to your medicine.
- Your problems (*symptoms*) get worse.
- You develop new problems.
- You lose feeling (*numbness*) or you cannot move (*paralysis*) any part of your body.
- You have tingling or weakness in any part of your body.
- Your pain is not controlled with medicine.
- You cannot take less pain medicine over time as planned.
- Your activity level does not improve as expected.

MAKE SURE YOU:
- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

Document Released: 06/05/2009 Document Revised: 03/11/2013 Document Reviewed: 09/20/2012

Chronic Back Pain

When back pain lasts longer than 3 months, it is called chronic back pain. People with chronic back pain often go through certain periods that are more intense (*flare-ups*).



CAUSES
Chronic back pain can be caused by wear and tear (*degeneration*) on different structures in your back. These structures include:

- The bones of your spine (*vertebrae*) and the joints surrounding your spinal cord and nerve roots (*facets*).
- The strong, fibrous tissues that connect your vertebrae (*ligaments*).

Degeneration of these structures may result in pressure on your nerves. This can lead to constant pain.

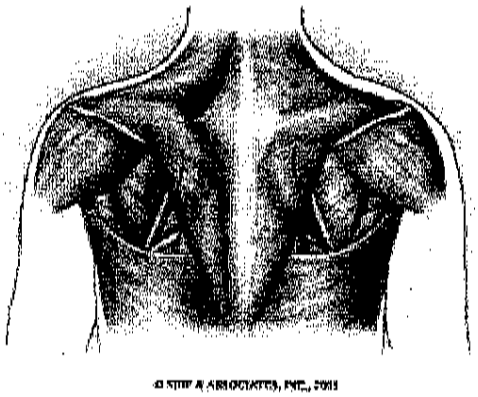
HOME CARE INSTRUCTIONS
- Avoid bending, heavy lifting, prolonged sitting, and activities which make the problem worse.
- Take brief periods of rest throughout the day to reduce your pain. Lying down or standing usually is better than sitting while you are resting.
- Take over-the-counter or prescription medicines only as directed by your caregiver.

SEEK IMMEDIATE MEDICAL CARE IF:
- You have weakness or numbness in one of your legs or feet.
- You have trouble controlling your bladder or bowels.
- You have nausea, vomiting, abdominal pain, shortness of breath, or fainting.

Document Released: 01/25/2006 Document Revised: 03/11/2013 Document Reviewed: 12/01/2012

Thoracic Strain

Thoracic strain is an injury to the muscles of the upper back. A mild strain may take only 1 week to heal. Torn muscles or tendons may take 6 weeks to 2 months to heal.



HOME CARE

- Put ice on the injured area.
  - Put ice in a plastic bag.
  - Place a towel between your skin and the bag.
  - Leave the ice on for 15 to 20 minutes, 3 to 4 times a day, for the first 2 days.
- Only take medicine as told by your doctor.
- Go to physical therapy and perform exercises as told by your doctor.
- Use wraps and back braces as told by your doctor.
- Warm up before being active.

GET HELP RIGHT AWAY IF:

- There is more bruising, puffiness (*swelling*), or pain.
- Medicine does not help the pain.
- You have trouble breathing, chest pain, or a fever.
- Your problems seem to be getting worse, not better.

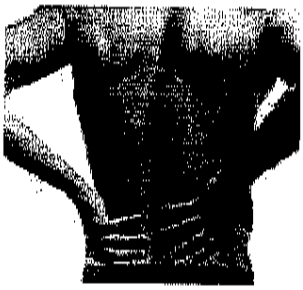
MAKE SURE YOU:

- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

Document Released: 06/05/2009 Document Revised: 03/11/2013 Document Reviewed: 02/06/2012

Sciatica

Sciatica is a name for lower back pain caused by pressure on the sciatic nerve. The back pain can spread to the buttocks and back of the leg.



HOME CARE

- Rest as much as possible.
- Only take medicine as told by your doctor.
- Apply cold or heat to your back as told by your doctor.
- **Do not** bend, lift, or sit for a long time until your pain is better.
- **Do not** do anything that makes the condition worse.
- Start normal activity when the pain is better.
- Keep all follow-up visits.

GET HELP RIGHT AWAY IF:

- There is more pain.
- There is weakness or numbness in the legs.
- You cannot control when you poop (*bowel movement*) or pee (*urinate*).

MAKE SURE YOU:

- Understand these instructions.
- Will watch this condition.
- Will get help right away if you are not doing well or get worse.

Document Released: 09/26/2009 Document Revised: 03/11/2013 Document Reviewed: 09/26/2009

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UPMC

Mercy Hospital

Forgot your insurance cards?

We will be glad to bill your insurance company for you, but please call us with your insurance numbers.

Insurance Verification Services

Please Call Within 48 Hours of Discharge

James Wade 412-232-5759

Deb Cidboy 412-232-7271

Your account number is: 033442688-4297

What we will need when you call:

Auto Accident (anything related to an automobile)

- Auto Insurance Claim #
- Auto Insurance Policy #
- Auto Insurance Claims Adjuster Name and Phone #
- Health Insurance info if you have any

Workers Comp Injury

- Your Work Address and Work Telephone #
- Employer's Name (Company and Supervisor)
- Workers Comp Insurance Company (if known)
- Health Insurance Info if you have any

Health Insurance

- Insurance Company Name
- Subscriber Name, SSN and DOB
- Insurance ID#
- Insurance Group#
- Insurance Telephone # and Address

EXHIBIT NO. 12F
PAGE: 26 OF 40

UPMC Mercy

1400 Locust St.
Pittsburgh, PA 15219

Bring This After Hospital Care Plan To ALL Appointments

After Hospital Care Plan For: FONTANA, TRISH A
Admission Date: 10/24/2014 4:19 PM

Questions about this packet?
412-232-7231

Discharging Provider/Nurse

Attending Physician: Robert Frank NPI Number: 1417944059
Nurse: Julie

EXHIBIT NO. 12F
PAGE: 27 OF 40

New prescriptions provided at the time of service

New Prescriptions:

IBUPROFEN 600 MG ORAL TABLET 1 TAB BY MOUTH FOUR TIMES A DAY FOR 7 DAYS; WITH FOOD OR MILK; ; MAY WITH OXYCODONE FOR MORE SEVERE PAIN; Dispense: 28 TAB(S); Refills: 0; Prescription Printed

ZOFRAN ODT 4 MG ORAL TABLET, DISINTEGRATING 1 TAB BY MOUTH FOUR TIMES A DAY FOR 2 DAYS; Dispense: 8 TAB(S); Refills: 0; Prescription Printed

OXYCODONE 10 MG ORAL TABLET 1 TAB BY MOUTH FOUR TIMES A DAY FOR 5 DAYS; Dispense: 20 TAB(S); Refills: 0; Prescription Printed

Medications Given in the ED:

None as per nursing (eMAR)

Medication Information Comment:

What is my main medical problem?
Cervical sprain; Lumbar strain; Motor vehicle accident

Appointment Details			
Provider	**Address**	**When**	**Comment**
DUSHAN MAJKIC	(412) 882-9455 BRENTWOOD MEDICAL GROUP 3028 BROWNSVILLE ROAD, PITTSBURGH, PA, 15227	WITHIN 3 TO 5 DAYS	IF YOUR CONDITION IS NOT IMPROVING

When scheduling your appointments, please confirm the address and telephone number listed is current. If you would like assistance in finding a doctor or making your appointments, please call (800) 533-UPMC (8762). It is *important* to keep all of your appointments.

Procedures/Tests Performed:

10/24 4:48 pm None

Summary of Relevant Procedures/Tests Performed:

The discharging provider did not include a summary of these tests. Please review these test results with your next care provider or primary care physician.

Labs Collected in the ED:

No lab data resulted.

EXHIBIT NO. 12F
PAGE: 28 OF 40

What are my medication allergies?

Allergies:

Mold; Mites; Pollen; Grass; penicillins [hives]; Pentothal [hives]; morphine [nausea/vomiting]

Visit Information Comment:

The care you received in the Emergency Department is only part of your ongoing health care. It is important that you make arrangements for follow-up with your primary physician or other appropriate physician or clinic. We recommend that you be seen for re-evaluation and further care as indicated in these Discharge Instructions.

Based on the information provided to us, we have reviewed your medications. Unless you were told otherwise, you should continue your medications as prescribed.

As part of UPMC's care and commitment, an electronic copy of your UPMC discharge instructions can be obtained via email. Please email your full name, date of discharge, date of birth and the hospital from which you were discharged to the email account Patient_instructions@upmc.edu to obtain an electronic copy.

UPMC Mercy would like to thank you for allowing us to assist you with your healthcare needs.

Emergency Medicine

Motor Vehicle Collision

It is common to have multiple bruises and sore muscles after a motor vehicle collision (MVC). These tend to feel worse for the first 24 hours. You may have the most stiffness and soreness over the first several hours. You may also feel worse when you wake up the first morning after your collision. After this point, you will usually begin to improve with each day. The speed of improvement often depends on the severity of the collision, the number of injuries, and the location and nature of these injuries.

HOME CARE INSTRUCTIONS

- Put ice on the injured area.
  - Put ice in a plastic bag.
  - Place a towel between your skin and the bag.
  - Leave the ice on for 15 to 20 minutes, 3 to 4 times a day.
- Drink enough fluids to keep your urine clear or pale yellow. **Do not** drink alcohol.
- Take a warm shower or bath once or twice a day. This will increase blood flow to sore muscles.
- You may return to activities as directed by your caregiver. Be careful when lifting, as this may aggravate neck or back pain.
- Only take over-the-counter or prescription medicines for pain, discomfort, or fever as directed by your caregiver. **Do not** use aspirin. This may increase bruising and bleeding.

SEEK IMMEDIATE MEDICAL CARE IF:

- You have numbness, tingling, or weakness in the arms or legs.
- You develop severe headaches not relieved with medicine.
- You have severe neck pain, especially tenderness in the middle of the back of your neck.
- You have changes in bowel or bladder control.
- There is increasing pain in any area of the body.
- You have shortness of breath, lightheadedness, dizziness, or fainting.
- You have chest pain.
- You feel sick to your stomach (*nauseous*), throw up (*vomit*), or sweat.
- You have increasing abdominal discomfort.
- There is blood in your urine, stool, or vomit.
- You have pain in your shoulder (shoulder strap areas).
- You feel your symptoms are getting worse.

MAKE SURE YOU:

- Understand these instructions.
- Will watch your condition.
- Will get help right away if you are not doing well or get worse.

Document Released: 12/18/2006 Document Revised: 03/11/2013 Document Reviewed: 05/16/2012

Trish Ann Fontana 197-56-3849

Exhibits

No. 5

EXHIBIT NO. 12F
PAGE: 31 OF 40

Fontana, Trish A DOB: 06/02/1967

Orthopedics Mercy Office
1350 Locust Street
Suite 220
Pittsburgh PA 15219-4736
Ph: 412 232 5800 Fax: 412-232-7351

Date: 11/19/2014
Name: Trish A Fontana
Address: 3130 GLENDALE AVE
PITTSBURGH, PA 15227
H: 412-882-0719
DOB: 06/02/1967
Gender: Female

CONSULT / REFERRAL TO PHYSICAL THERAPY

Referral

Date: 11/19/2014
Requested By: Orthopedics Mercy Office

Associated Diagnoses

Cervical strain (847.0) - Primary

Priority	CPT	Quantity
Routine	9032	1

Order Questions and Answers

Order Entry

Duration 1-3 times per week

Referred To Information

Prov Specialty
Physical Therapy

Comments

Eval and Treat
Diagnosis
Cervical Pain
Cervical Neck Pain/Injury
Upper Extremity Strengthening

Electronically Signed by:
Richman, Jory D, MD

Lic#: MD046590L NPI#: 1740265065

Allergies as of 11/19/2014

Allergies Reviewed 10/15/2014
Donaldson, Amanda

Allergen	Noted	Type	Reactions
Morphine	06/12/2012		
Paper Tape (Adhesive Tape)			Unknown Reaction
Pen (Penicillin G Benzathine & Proc)	06/12/2012		

EXHIBIT NO. 12F
PAGE: 32 OF 40

Orthopedics Mercy Office	1350 LOCUST STREET SUITE 220 Pittsburgh PA 15219-4738	412-232-5800	412-232-7351

After Visit Summary

11/19/2014 Office Visit

Trish A Fontana

11/19/2014 2:40 PM Jory D Richman

Female	Jun 2, 1967	47 year old	White	Not Hispanic or Latino	English

Pain — neck and back pain

Cervical strain - Primary — 847.0

Return in 6 weeks (on 12/31/2014).

5' 2" (1.575 m) 115 lb (52.164 kg)

21.03 (kg/m^2) 1.51 (m^2)

CONSULT / REFERRAL TO PHYSICAL THERAPY

Please review the list of medications below. The medications reviewed and confirmed by you at today's visit are listed first and display the word (Taking). Additional medications on this list are part of your active medication list in our electronic medical record but you did not indicate today that you were taking them.

If any corrections are needed or if you have questions, please contact the doctor who ordered the medication or your primary care provider.

gabapentin (NEURONTIN) 100 mg oral capsule (Taking)	Take 1 capsule by mouth 3 times a day
HYDROcodone-acetaminophen (NORCO) 5-325 mg oral tablet (Taking)	Take 1 tablet by mouth daily as needed
ibuprofen (MOTRIN) 800 mg oral tablet	Take 1 tablet by mouth every 8 hours as needed for pain

Trish Ann Fontana 197-56-3849

Exhibits

No. 6

EXHIBIT NO. 12F
PAGE: 34 OF 40

Social Security Administration
Retirement, Survivors and Disability Insurance

SOCIAL SECURITY
SUITE 120
650 WASHINGTON ROAD
PITTSBURGH, PA 15228-2706
Date: November 13, 2013
Claim Number: 197-56-3849
CR

LAWRENCE E BOLIND JR
ESQUIRE
238 MAIN ST
IMPERIAL, PA 15126

Dear LAWRENCE E BOLIND JR ESQUIRE

We have received written notice that TRISH A FONTANA has appointed you to act as the representative in connection with this claim(s) under the Social Security Act (the Act). We will, therefore, be dealing directly with you on matters pertaining to this claim(s).

Generally, to charge a fee for services, you must use one of two, mutually exclusive fee approval processes. You must file either a fee petition or a fee agreement with us. In either case, you cannot charge more than the fee amount we approve.

Fee Petition Process

You may ask for approval of a fee by giving us a fee petition when you have completed your services to the claimant. This written request must describe in detail the amount of time spent on each service provided and the amount of the fee you are requesting.

Fee Agreement Process

If you and the claimant have a written fee agreement that you have not already submitted, either of you must give it to us before we decide the claim(s). We usually will approve the agreement if you both sign it; the fee you agreed on is no more than 25 percent of past-due benefits, or $6,000 (or a higher amount we set and announce in the Federal Register), whichever is less; we approve the claim(s); and the claim results in past-due benefits.

If you do not file a fee agreement, you may use Form SSA-1560-U5 (PETITION TO OBTAIN APPROVAL OF A FEE FOR REPRESENTING A CLAIMANT BEFORE THE SOCIAL SECURITY ADMINISTRATION) to petition for approval of the fee you wish to charge. File the SSA-1560-U5 when the proceedings are complete and your services have ended. If you are an attorney or a non-attorney whom SSA has found eligible to receive direct payment and you seek direct payment from the claimant's title II or title XVI past-due benefits, you must file the SSA-1560-U5, or a notice of intent to petition for a fee within 60 days of the notice of the favorable determination. Further information and instructions for completion are given on the form itself.

See Next Page

EXHIBIT NO. 12F
PAGE: 35 OF 40

197-56-3849

After we approve a fee, you must look to the claimant for payment, except when you are an attorney or non-attorney who is eligible to receive direct payment and there are past-due benefits payable under title II or title XVI of the Act as a result of a favorable determination on the claim. In such cases, we will pay up to 25 percent of such past-due benefits directly to you toward payment of the approved fee and charge you the assessment required by sections 206(d) and 1631(2)(2)(C) of the Social Security Act. You cannot charge or collect this expense from the claimant.

If you wish to waive either a fee or direct payment of a fee and you have not already done so, you should sign and date the appropriate box below or send us a letter with an appropriate statement. Early filing of the waiver will enable us to prevent the automatic withholding of past-due benefits for possible direct payment.

Social Security Administration

WAIVER OF FEE - I waive my right to charge and collect a fee under sections 206 and 1631(d)(2) of the Social Security Act. I release my client (the claimant) from any obligation, contractual or otherwise, which may be owed to me for services I have provided in connection with my client's claim(s) or asserted right(s).

Laura E. Bolind 12-2-14

SIGNATURE (Representative) DATE

WAIVER OF DIRECT PAYMENT BY ATTORNEY OR NON-ATTORNEY ELIGIBLE TO RECEIVE DIRECT PAYMENT - I waive only my right to direct payment of a fee from the withheld past-due retirement, survivors, disability insurance or supplemental security income benefits of my client (the claimant). I do not waive my right to request fee approval and to collect a fee directly from my client or a third party.

Trish Conn Fontana 12-2-14

SIGNATURE (Representative) DATE

Trish Ann Fontana 197-56-3849

Exhibits

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EXHIBIT NO. 12F
PAGE: 37 OF 40

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

Form Approved
OMB No.0960-0289

CLAIMANT'S MEDICATIONS

A. To be completed by Hearing Office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number) (Leave blank if same as claimant)	The last time we brought your case up-to-date was:
Trish Ann Fontana 197-56-3849		September 16, 2013

B. To be completed by the claimant

PLEASE PRINT

PLEASE LIST BELOW THE PRESCRIPTION MEDICATION WHICH YOU ARE PRESENTLY TAKING. IF THE NAME OF THE MEDICATION IS NOT SHOWN ON THE PRESCRIPTION CONTAINER, YOU MAY VERIFY THE NAME WITH YOUR PHARMACIST.

NAME OF MEDICATION & DOSAGE	DATE FIRST PRESCRIBED	DAILY AMOUNT TAKEN	REASONS FOR MEDICATION	NAME OF PHYSICIAN
OXYCODONE	6-2011	1-2 per. Day	Back Pain Leg Pain	Dr. Jory Richman
IBUPROFEN	10-2011?	1-every 8hrs. PRN needed	BACK PAIN Leg PAIN	DR. JORY Richman
NEUROTIN	10-15-15	1-3x Daily	nerve pain	DR. JORY Richman
Tramadol	10-15-15	1-every 6 hours	Back Pain Leg Pain	DR. JORY Richman

PLEASE LIST BELOW THE NONPRESCRIPTION MEDICATION YOU ARE TAKING AND THE REASONS YOU TAKE THEM.

Zyrtec - Allergies

Form HA-4632 (2-1994) ef (6-2009)
Use Until Stock Is Exhausted

If more space is needed, use additional sheets.

RQID:0000000000000128124487 SITE:Y12 OR:S
SSN:197563849 DOCTYPE:3045 RF:D CS:aabb

EXHIBIT NO. 12F
PAGE: 38 OF 40

SOCIAL SECURITY ADMINISTRATION
Office of Disability Adjudication and Review

Form Approved
OMB No.0960-0300

CLAIMANT'S WORK BACKGROUND

A. To be completed by Hearing Office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number) (Leave blank if same as claimant)	The last time we brought your case up-to-date was:
Trish Ann Fontana 197-56-3849		September 16, 2013

B. To be completed by the claimant

PLEASE PRINT

Start with your most recent job, and list that and any work performed within the past 15 years.

DATE OF EMPLOYMENT (APPROXIMATELY)	NAME OF EMPLOYER AND LOCATION OF EMPLOYMENT	DUTIES PERFORMED
FROM Sept 07	OK Grocery	Loading Trucks
TO 4 Jan - 2010	[redacted]	Driving Jack
	Warehouse	
	Crafton, PA	
FROM	Matrix Property	Title Searcher
TO	Settlements	
	2933 Peters Run RD.	
	White Oak, PA 15131	
FROM		
TO		

Form HA-4633 (3-1994) ef (6-2009)
Issue Old Stock

If more space is needed, use additional sheets.

RQID:0000000000000128124489 SITE:Y12 DR:S
SSN:197563849 DOCTYPE:3050 RF:D CS:2851

EXHIBIT NO. 12F
PAGE: 39 OF 40

Social Security Administration
Office of Disability Adjudication and Review

Form Approved
OMB No.0960-0292

CLAIMANT'S RECENT MEDICAL TREATMENT

A. To be completed by hearing office

(Claimant and Social Security Number)	(Wage Earner and Social Security Number) (Leave blank if same as claimant)	The last time we brought your case up-to-date was:
Trish Ann Fontana 197-56-3849		September 16, 2013

B. To be completed by claimant

PLEASE PRINT

Please Answer the Following Questions:

(1) Have you been treated or examined by a doctor (other than a doctor at a hospital) since the above date? ☑ Yes ☐ No

(If yes, please list the name, addresses and telephone numbers of doctors who have treated or examined you since the above date. Also list dates of treatment or examination. If possible, send updated reports from these doctors to the Administrative Law Judge prior to the date of your hearing.)

DOCTORS' NAME(S)	ADDRESS(ES) & TELEPHONE NO.(S)	DATE(S) ~~April 2014~~
DR. Joby Richman	1350 Locust St pgh. PA 15219	July-2014
		August 2014
		Oct. 2014
		Nov. 2014

(2) What have these doctors told you about your condition?

I have Spinal Stenosis, degenerate Disc Disease Sciatica, with no Improvement, we discussed the optuon of a posterior lumbar decompression and fusion at L4-5

(3) Have you been hospitalized since the above date? ☐ Yes ☒ No

(If yes, please list the name and address of the hospital. Also explain why you were hospitalized and what treatment you received.)

Name of Hospital	Address of Hospital (Include ZIP Code)

Reason for hospitalization:

Treatment received:

Form HA-4631 (8-1996) ef (6-2009)
Issue Old Stock

If more space is needed, use additional sheets.

RQID:0000000000000128124486 SITE:Y12 DR:S
SSN:197563849 DOCTYPE:3848 RF:0 CS:fa6d

EXHIBIT NO. 12F
PAGE: 40 OF 40

WHOSE Records to be Disclosed	Form Approved OMB No. 0960-0623
NAME (First, Middle, Last, Suffix) Trish Ann Fontana	
SSN 197-56-3849	Birthday (mm/dd/yy) 08/02/1967

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW **

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT *All my medical records; also education records and other information related to my ability to perform tasks. This includes specific permission to release:*

1. All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to :
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.
3. Copies of educational tests or evaluations, including Individualized Educational Programs, triannial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.
4. Information created within 12 months after the date this authorization is signed, as well as past information.

FROM WHOM

- All medical sources (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM The Social Security Administration and to the State agency authorized to process my case (usually called "disability determination services"), including contract copy services, and doctors or other professionals consulted during the process. [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my eligibility for benefits, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am capable of managing benefits ONLY (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- I have read both pages of this form and agree to the disclosures above from the types of sources listed.

PLEASE SIGN USING BLUE OR BLACK INK ONLY INDIVIDUAL authorizing disclosure	IF not signed by subject of disclosure, specify basis for authority to sign ☐ Parent of minor ☐ Guardian ☐ Other personal representative (explain)
SIGN ▶ Trish Ann Fontana	(Parent/guardian/personal representative sign here if two signatures required by State law) ▶
Date Signed 12-2-14	Street Address 3130 Glendale Avenue
Phone Number (with area code) (412)882-0719	City Pittsburgh State: PA ZIP: 15227

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶	IF needed, second witness sign here (e.g., if signed with "X" above) SIGN ▶
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.